REQUEST FOR HUMAN WEST NILE VIRUS TESTING 2001—
PATIENT INTAKE FORM (Page 1 of 3)

FOR NJDHSS USE ONLY	**NJ ID** _____	
Date report received ___/___/___	Received by _____	Record entry date ___/___/___
Reported from: [] MD, hospitalized patient [] ICP [] Report from other state	[] MD, outpatient [] Commercial laboratory [] Other _____	Approved for WNV testing? [] Yes [] No

***REQUIRED INFORMATION*-- REPORTS WILL NOT BE PROCESSED IF THESE FIELDS ARE NOT COMPLETED. PLEASE PRINT ALL INFORMATION.**

***Date ___/___/___**

1. *IDENTIFYING PATIENT INFORMATION

Last name |___|___|___|___|___|___|___|___|___|___|___|___|

First name |___|___|___|___|___|___|___|___|___|___|___|___| Middle initial |___|

Date of birth ___/___/___ Age _____ years Sex [ ] Male [ ] Female

Street address _____ Apt _____

City _____ County _____ State _____ Zip _____

Home phone (____) _____-_____ Work phone (____) _____-_____

2. *REPORTED BY:

Last name _____ First name _____

Title (ICP, Resident, Attending, etc.) _____

Specialty (if applicable) _____

Work address _____

City _____ State _____ Zip _____

Telephone (____) _____-_____ Pager (____) _____-_____ Fax (____) _____-_____

3. ADDITIONAL MEDICAL CONTACT PERSON (if different from the person reporting)

Last name _____ First name _____

Title (ICP, Resident, Attending, etc.) _____

Specialty (if applicable) _____

Work address _____

City _____ State _____ Zip _____

Telephone (____) _____-_____ Pager (____) _____-_____ Fax (____) _____-_____

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4. *CLINICAL INFORMATION

Admitting diagnosis [ ] encephalitis [ ] meningoencephalitis [ ] meningitis
[ ] Guillian-Barre syndrome [ ] other (specify)

Was the patient hospitalized? [ ] Yes [ ] No

Hospital name _____ City _____ State _____

Medical record number _____

Admission date ___/___/___ Date of discharge ___/___/___

***Required*-- Date of first symptoms ___/___/___**

Fever	[ ] Yes	[ ] No	[ ] Unknown	Stiff neck	[ ] Yes	[ ] No	[ ] Unknown
Headache	[ ] Yes	[ ] No	[ ] Unknown	Photophobia	[ ] Yes	[ ] No	[ ] Unknown
Altered mental status	[ ] Yes	[ ] No	[ ] Unknown	Seizure	[ ] Yes	[ ] No	[ ] Unknown
Muscle weakness	[ ] Yes	[ ] No	[ ] Unknown	Rash	[ ] Yes	[ ] No	[ ] Unknown

Other neurologic signs [ ] Yes _____ [ ] No [ ] Unknown
(specify)
Other symptoms [ ] Yes _____ [ ] No [ ] Unknown
(specify)
Antiviral treatment [ ] Yes _____ [ ] No [ ] Unknown
(specify)
Antibiotic treatment [ ] Yes _____ [ ] No [ ] Unknown
(specify)

Patient's outcome [ ] Recovered [ ] Still ill, hospitalized [ ] Still ill, discharged home
[ ] Died (Date of death) _____ [ ] Rehabilitation [ ] Unknown

5. *LABORATORY AND DIAGNOSTIC TESTING RESULTS

Lumbar puncture performed? [ ] Yes (Date performed _____) [ ] No [ ] Pending/planned

CSF results: Glucose _____ Protein _____ RBC _____ WBC _____ % lymph _____ %segs _____

Gram stain _____ Bacterial culture _____

Parasitic or fungal culture _____

Viral culture _____

If performed:

CBC Date ___/___/___ WBC _____ % lymph _____ %segs _____

MRI Date ___/___/___ Result _____

CT Date ___/___/___ Result _____

EMG Date ___/___/___ Result _____

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5. RISK FACTOR INFORMATION

Travel within the U.S.? [ ] Yes _____ [ ] No [ ] Unknown
(location) (start and end dates of travel)

Travel outside of the U.S.? [ ] Yes _____ [ ] No [ ] Unknown
(location) (start and end dates of travel)

Animal or arthropod contact? [ ] Yes _____ [ ] No [ ] Unknown
(specify) (date of contact)

6. VACCINATION HISTORY

History of yellow fever vaccination [ ] Yes _____ [ ] No [ ] Unknown
(date of vaccination)

History of Japanese encephalitis vaccination [ ] Yes _____ [ ] No [ ] Unknown
(date of vaccination)

History of other tick-borne encephalitis vaccination [ ] Yes _____
(date and type of vaccination)

[ ] No [ ] Unknown

7. ADDITIONAL REPORTER INFORMATION

What did you find was the most useful source of information about WNV human surveillance reporting?

[ ] Hospital ICP
[ ] Hospital laboratory
[ ] NJDHSS e-mail
[ ] NJDHSS website
[ ] Other _____

Please fax completed form to (609) 631-4863, attention: WNV Human Surveillance, Communicable Disease Service, NJDHSS.

Once a report is received at the NJDHSS, staff will contact you on whether this patient is approved for WNV testing. If approved for testing, we will provide additional information on shipping specimens.

If you have any questions, please call (609) 588-7500.